The Economic
Progress Institute

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formerly The Poverty Institute

To: The RI Executive Office of Health and Human Services

Re: Comments on Request to Extend the Rhode Island 1115 Research and Demonstration Waiver
Project No. 11-W-00242/1

Date: March 1, 2013

The Economic Progress Institute is a policy and advocacy organization dedicated to improving the economic security of low and modest income Rhode Islanders. Access to affordable health care and an efficient and consumer-responsive Medicaid program is key area of focus. Staff has been engaged in advocacy around Rhode Island's Medical Assistance program dating back to 1993 when the first Section 1115 waiver to implement the RIte Care program was submitted. We monitor and provide analysis and advocacy on the full range of Medicaid services and populations. We helped to facilitate a coordinated cross-population community response to the initial "Global Waiver" proposal in 2008 and have actively participated in the Global Waiver Task Force convened by OHHS.

We appreciate the opportunity to provide comments on the proposed Request to Extend the Section 1115 Waiver. Overall, we believe that the Extension request includes many proposals that will improve access to appropriate health care for Medicaid participants by addressing the complex needs of low-income populations and promoting quality community-based services for people who require long term services and support. The proposal will ensure that federal and state investments are used efficiently to promote the purposes of the Medicaid program. We like the new "Guiding Principles" articulated in the Program Description and are especially pleased that during the Extension period there will be a concerted effort to integrate access to services, including long term services and supports, across the agencies within OHHS and the populations that these agencies traditionally serve.

We suggest adding an additional Guiding Principle addressing consumer empowerment and promoting good health care decision-making. Consumers need to be part of the reform of the health care delivery system by using care appropriately, making decisions that will promote good health and being partners with their providers in managing their care. Suggestion for a new Guiding Principle: "Ensure that Medicaid participants are informed consumers of health care services and active participants in managing their care".

We have the following additional comments on the other Sections of the Proposed Extension:

Eligibilty

Medicaid Expansion.We are very pleased that Rhode Island will be expanding Medicaid to low-income adults without children in their care.

Optional Eligibility Groups and RIte Care Expansion Group.We are pleased that the Proposed Extension retains all optional eligibility groups and continues coverage for parents with income up to 175% FPL, pregnant women up to 250% FPL and children up to 250% FPL. These groups are included as "Groups that could be covered under the state plan but gain eligibility through the 1115 Demonstration" ("RIte Care expansion"). In the original waiver (at par 26) there is a requirement for "maintenance of current optional populations". This requirement provides that if the state plans to make any changes affecting these populations, it must give priority to extension or continuation of eligibility for optional populations prior to extension or continuation of eligibility for groups not otherwise eligible under the state plan. This puts the "RIte Care expansion" population at a disadvantage that is a solely a result of the decision to provide eligibility through the waiver instead of through the state plan. If Paragraph 26 continues to apply, then we request that either (1) Paragraph 26 be amended to provide equal status to the Rite Care expansion population or (2) move the Rite Care expansion population from waiver eligibility to eligibility through the state plan.

Eligibility Groups and ACA.We expect that the list of eligibility groups will be revised to reflect the realignment of groups as implemented by the Affordable Care Act.

Family Planning Services.We recommend that the Extension revise the current family planning coverage group to include women and men who do not otherwise have access to these services. The income limit applied to the currently eligible group (women who lose Medicaid 60 days post-partum) would be applied to the expanded group. Since many of the men and women who might seek these services will be eligible for full Medicaid under the new expanded eligibility and some may enroll in commercial insurance with the new APTC, we expect that the number of individuals seeking this coverage will be limited. Moreover, since the FMAP for these services is 90%, the cost to the state should be fairly minimal. We also propose that the income standard for family planning services, which is currently listed as 200% FPL, be revised to 250% FPL. This would make the income standard the same as that for pregnant women and we can see no reason to deny family planning services to a subset of women who have Medicaid eligibility while they are pregnant. We note that the current RIte Care regulations provide for extended family planning for all women who have received RIte Care during pregnancy, so we assume that current practice is to provide coverage for women up to 250% FPL.

Substitute Care - Budget Population 8. We propose that the criteria for this CNOM population be revised to eliminate the requirement that the reason for the child's removal from the home is because of the parent's behavioral health conditions. Children may be removed for other reasons and as long as the

removal is for a temporary period of time, the parent should continue to be enrolled in RIte Care so she has access to comprehensive health care. We note that most, if not all, of the parents in this CNOM group will now be eligible for Medicaid under the expansion group, but as long as there is proposed coverage for those who may have income above 138% FPL and below 200% FPL, the reason for removal should not matter.

Eligibility Procedures

Expedited Long Term Care Service (LTSS). We like the proposal to expedite access to community-based LTSS by accepting self-attestation of financial eligibility criteria for up to 90 days. We recommend allowing a more extensive set of services during this "presumptive eligibility period". The services should be tailored to the applicant's needs to avoid entry to a nursing home. If five days of Adult Day Care Services are what is required, because a care-giver is not available, for example, that is what should be allowed. EOHHS should closely examine the current requirements for establishing financial eligibility and look for ways to streamline that process so that a full eligibility assessment can be accomplished as quickly as possible.

Continuity of Coverage Between Exchange and Medicaid. We are pleased to see this proposal which we agree will help ensure continuity of care for people transitioning between Medicaid and QHP.

Express Lane Eligibility. We recommend that EOHHS implement express lane eligibility for adults and for children after 2013. This is a proven way to streamline access to health insurance coverage for consumers and reduces the administrative burden for the agency.

Presumptive Eligibility. It is not clear whether EOHHS is proposing to implement presumptive eligibility which we do not believe is currently in effect. There is reference, in Question 2, to the fact that if a hospital elects to implement presumptive eligibility, it will be required to become a Navigator. If EOHHS is proposing to implement presumptive eligibility, then it should be available to consumers regardless of where they apply for coverage.

Benefits

Benefit package. We are pleased that EOHHS will keep intact the current benefit package and that the newly eligible Medicaid expansion population will have this same benefit package. This will ensure that all Medicaid beneficiaries have access to the health care services they need to attain and maintain good health.

Potential New Services. We like the list of new services that EOHHS is considering. We appreciate that the EOHHS wants to maintain the Program Flexibility established in the original waiver which establishes different processes for making "Category I, II and III" type changes. Most of the changes during the first five years have been Category II type changes. There has not been consistency in providing the public opportunity to comment on these changes before they are submitted to CMS. We request that in the

Extension period, EOHHS agrees to establish a consistent process for prior notice of Category II (and III) changes with an opportunity for public comment. Often the persons and entities that will be affected by the proposed change can provide valuable information to OHHS about the impact and viability of the proposed change. Having a standardized and open process also helps to increase the community's trust in the administration of the Medicaid program.

Cost-Sharing

Co-payments and Premiums. We agree with eliminating co-payments as part of cost-sharing (with the exception of EFP) since point of service payments can be a barrier to participants seeking the care they need. We request that EOHHS consider also eliminating the RIte Care premiums to ensure affordability of health insurance coverage for lower-income families. The RIte Care premium is a family-based premium, not a per-person premium. Under the Affordable Care Act parents who are not eligible for RIte Care will be required to purchase health insurance coverage for themselves, the cost of which will also be based on family income. The net result is that the total cost of health insurance coverage for children and parents will be unaffordable for the family. For example, a parent with two children with income of twice the poverty level will need to pay $77/month for her children's coverage through RIte Care (2.4% of income) and around $200/month for her own coverage through the Exchange (6.2% of income). The total cost of health insurance for the family will consume 8.6% of income, higher than both our state law and the ACA suggest is appropriate.

Under the current rules, an average of 149 families/month lost RIte Care coverage in calendar year 2012 for failing to pay the monthly premium and parents and/or children were uninsured for four months, disrupting access to care.

Rhode Island's premiums are higher than the other New England states. Only two other states require premiums at 151% FPL as does Rhode Island and the required amounts at that level are significantly lower than the $61 RIte Care premium.

Eliminating the RIte Care premiums would ensure that the lowest-income families (with income below 175% FPL) do not lose access to coverage or care because of financial reasons and would make it more likely that low income parents in families with income between 175% and 250% FPL will be able to afford enrollment through the Exchange. By eliminating premiums we would ensure that no child lost coverage because their family could not afford their insurance. In addition, OHHS would be relieved of the administrative cost of collecting the premiums. Most importantly, we would ensure that children and low-income parents had continuous access to care.

We recognize that this change would require a statutory amendment, but recommend that it be included in the Extension Proposal with the caveat that this would require General Assembly approval.

Delivery System and Payment Rates for Services

We are pleased that EOHHS will be expanding the RIte Smiles program to older children and adults. This has proved to be an effective way to improve access to dental care.

Budget Neutrality

We are very pleased that EOHHS is proposing to remove the federal financing cap and think the reasons for doing so were accurately described. Using the traditional budget neutrality arrangement is much less risky for the state and beneficiaries who rely on the Medicaid program. We request that the public be afforded the opportunity to review and comment on the financial assumptions and methodologies that are being developed for the "without waiver" and "with waiver" forecasts and especially the adjustments to the baseline forecasts. The Proposed Extension accurately captures the categories of adjustments that will need to be made. Given the complexity of the adjustments, especially those related to ACA implementation, it would be useful for the public to review the assumptions and provide feedback.

Evaluation

The document only provides evaluation of part of the Medicaid program and populations served. There is no evaluation provided concerning services provided by BHDDH for persons with developmental disabilities and/or serious and persistent mental illness or for services provided by DCYF for children. There is also no evaluation of HIV Services as specifically required in STC Paragraph 94. We request that the Waiver Extension include any existing evaluation of services provided to the populations served by BHDDS and DCYF, as well as evaluation of HIV services.

Most importantly, we request that there be specific plans for evaluation of the Section 1115 Waiver Extension that includes all populations and services.

Community Participation

EOHHS should include a commitment to continue to facilitate a community advisory committee to the Demonstration waiver/Medicaid program. We appreciate the difficulty of doing this and the effort EOHHS has made so far with the Global Waiver Task Force. It is clear that community members want a way they can provide meaningful input to EOHHS on programmatic and service issues and work with EOHHS staff to ensure good outcomes for Medicaid consumers. In addition, community members want to receive quantitative and qualitative data to be able to monitor how well the program is serving the needs of recipients.

We suggest that the current Global Waiver Task Force could be reformed to become the Medicaid Advisory Committee, which would have 3 subcommittees focused on the three key populations served by Medicaid: (1) Children and Families (including children with special health care needs), (2) Adults

(seniors and the new expansion population), and (3) Adults with Disabilities. Staff from EOHHS agencies would participate in the subcommittees (e.g.: EOHHS and DCYF – Children and Families; EOHHS, DEA – Adults; EOHHS and BHDDH – Adults with Disabilities). The subcommittees would be a place for staff and community members to problem solve issues and identify "cross over" issues between subcommittees. The full Medicaid Advisory Committee would receive the input and recommendations from the subcommittees, as well as be a forum for sharing data with community members.

Closing

Thank you for consideration of these comments. We look forward to reviewing the proposal that EOHHS submits to CMS and EOHHS's response to these and other comments submitted.

Linda Katz
Policy Director